Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $905.00 for date of service, 03/20/01.

   b. The request was received on 03/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial Submission of TWCC-60
      1. HCFA 1500
      2. EOB(s)
   b. Additional documentation requested on 05/28/02 and received on 06/10/02
      1. Position statement dated 01/31/02
      2. Request for reconsideration letters dated 09/04/02 and 12/17/01
      3. HCFA 1500
      4. EOB(s)
      5. Test results dated 03/20/01
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/27/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 07/01/02. The response from the insurance carrier was received in the Division on 07/15/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 01/31/02

   "The majority of my position will be found in the enclosed documents…. The enclosed documents will illustrate the lack of appropriate knowledge on their part. As a result of this, I'm forced to spend a lot of time going through the whole medical dispute process from which I will lose money and the Commission will spend their time to the detriment

of more worthy cases. This is a simple case of Dr… being a designated doctor per the TWCC Rule 130.6 (m) and he has latitude to order reasonable tests in his discretion."

2. Respondent: The response was not timely and consequently not eligible for review.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/20/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $3,830.00 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $356.00 for services rendered on the date of service in dispute above and denied any additional reimbursement as "F – T,N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED."

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $905.00 for services rendered on the date of service in dispute above.

6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/20/01 03/20/01 03/20/01 03/20/01	95900 95904 95935 95925	$660.00 $750.00 $900.00 $1,520.00	$128.00 $0.00 $53.00 $175.00	F, T, N for all codes	$64.00/nerve $64.00/nerve $53.00 $175.00	STG (e) (2) (3); MFG MGR (IV); CPT Descriptor	The Carrier's EOBs deny additional reimbursement as "F – T, N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED. This EOB does not meet the requirements of TWCC Rule 133.304 (c) regarding explanation of benefits denials. This rule states, "…shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." In a request for reconsideration letter to the Carrier, the provider states a Carrier representative "…ask me what nerves were tested and I read from the interpretive report which spelled out each nerve…". It would appear the provider was aware what additional information was needed to satisfy the Carrier's denial request. While the provider has submitted the interpretation of the studies, no actual testing documentation was submitted to indicate and verify which nerves were tested. Therefore, documentation does not support services as billed and no additional reimbursement is recommended.
Totals		$3,830.00	$356.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 1st day of October 2002.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt